EXHIBIT A

National Health Insurance Company
1901 N. State Highway 360, Grand Prairie, TX 75050

GROUP SHORT TERM MEDICAL INSURANCE

THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER THE GROUP SHORT TERM MEDICAL INSURANCE POLICY. BENEFITS PROVIDED ARE LIMITED AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

CERTIFICATE OF COVERAGE

Issued under the terms of

Group Insurance Policy Number: 10001GA_2I1FNA - MM658705460

Issued to: LIFE Association
(herein called the Policy Holder)

Policy Date: 07/01/2015

National Health Insurance Company hereby certifies that members of the class(es) eligible for insurance are insured under the above Policy as determined by the Eligibility and Certificate Effective Date provisions. Class is defined in the Certificate Schedule.

This Certificate is evidence of insurance provided under the Policy. All benefits are paid according to the terms of the Policy. This Certificate describes the essential features of the insurance coverage.

In this Certificate, the words "Covered Person" or "You" means a member of an eligible class as described on the Certificate Schedule, who is insured under the Policy and for whom premiums are remitted. The words "Covered Person" refer to any person covered under the Policy as described on the Certificate Schedule. The words "We", "Us", "Our" or "Company" refer to National Health Insurance Company. "Policy" means the Group Short Term Medical Insurance Policy issued to the Policy Holder and available for review by You. If the terms of Your Certificate of coverage and the Policy differ, the Policy will govern. We have the right to change the premium We charge. If We plan to make a change, We will send the Policyholder a notice at least 60 days before We make it.

The Policy and this Certificate may be changed in whole or in part or cancelled as stated in the Policy. Such action may be taken without the consent of or notice to any Covered Person. Only an authorized officer at Our home office can approve a change. The approval must be in writing and endorsed on or attached to the Policy. No other person, including an agent, may change the Policy or Certificate or waive any of its provisions.

The use of the pronoun "he" refers to both male and female members whenever used.

TO OBTAIN INFORMATION YOU MAY CALL OUR TOLL FREE NUMBER: 1-888-781-0585

For National Health Insurance Company:

Jeffrey Wiseman
Secretary

Charles W. Harris
President

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKER'S COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.

Limited Benefit, Please Read Carefully

THE COVERAGE IS NON-RENEWABLE SHORT TERM INSURANCE.

IT WILL NOT BE RENEWED AT THE END OF THE COVERAGE PERIOD.

READ THIS CERTIFICATE CAREFULLY.

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NOTE: NO CONTINUOUS COVERAGE. The policy of insurance provides coverage for a short term limited duration only. It is not renewable. Although coverage under the short term policy may be rewritten for new and completely separate Coverage Periods (as long as You meet the eligibility criteria described in the application), coverage does not continue from one policy to another. This means that (1) a new application must be submitted, (2) a new effective date will be given, (3) a new pre-existing condition exclusion period will begin and (4) a new deductible and maximum out-of-pocket expense must be met. Any medical condition which may have occurred and/or existed under a prior policy will be treated as a pre-existing condition under the new policy.

BENEFIT SCHEDULE

The benefit specifications are shown on the following attachment which is hereby made a part of this Certificate:

NHIC GP STM ASSC-CERT TX 2014-SCHED	Benefit Schedule

GENERAL DEFINITIONS

Additional definitions may be contained in other benefit provisions or any endorsement or rider.

Accident
Accident means a sudden, unforeseeable event that causes injury to one or more Covered Persons, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition. In addition the accident must not be excluded by name or specific description in this Certificate.

Ambulatory Surgical Center
An *Ambulatory Surgical Center (ASC)* is a distinct entity that operates exclusively for the purpose of furnishing Outpatient surgical services. The *Ambulatory Surgical Center* must be certified with the Center for Medicare and Medicaid Services (CMS.) An *ASC* is either an independent facility or is operated by a Hospital. A Hospital-operated facility must be a separately identifiable entity, physically and administratively, and be financially independent and distinct from other operations of the Hospital.

Coinsurance Percentage
Coinsurance Percentage means the applicable percentage specified on the Benefit Schedule that We will use in calculating the amount payable for a benefit.

Complications of Pregnancy
Complications of Pregnancy are health conditions requiring medical treatment before or after termination of pregnancy. The health condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis; cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar conditions that cannot be classified as a distinct complication of pregnancy but are connected with the management of a difficult pregnancy. Also included are: medically necessary cesarean sections; terminated ectopic pregnancy; spontaneous termination that occurs during pregnancy in which a viable birth is impossible; hyperemesis gravidarum; and preeclampsia.

Complications of Pregnancy do NOT include: false labor; occasional spotting; rest prescribed during the period of pregnancy; or elective cesarean section.

Confined or Confinement
Confined or *Confinement* means the assignment to a bed as a resident inpatient in a Hospital or a licensed Skilled Nursing Facility on the advice of a Doctor, or Confinement in an Observation Unit within a Hospital for a period of no less than 24 continuous hours on the advice of a Doctor.

Copay
Copay means the amount required to be paid by a Covered Person each time a specific service is provided, as set forth on the Benefit Schedule. Copay amounts are deducted before any applicable Deductible or Coinsurance Percentage is applied.

Covered Expenses
Covered Expenses means expenses for treatments, services and supplies which a Doctor recommends (1) as Medically Necessary to treat a Sickness or Injury; (2) which are Usual, Reasonable and Customary; and (3) which do not exceed any amount payable under the terms of the Policy.

Covered Person(s)
You and Your Dependents who are insured under the Policy.

Day
Day means a single calendar Day from midnight to midnight, including weekends. Benefits are payable for each calendar Day a covered service is performed. For each covered benefit, multiple procedures performed on a single calendar Day shall be considered a single calendar Day for the benefit.

Deductible
Deductible means the amount of Covered Expenses that each Covered Person must pay before benefits will be payable. The Deductible is shown on the Benefit Schedule.

Deductible Family Maximum: The total amount of Deductibles that must be met by all Covered Persons during the Coverage Period before no further Deductibles are required to be satisfied. The Deductible Family Maximum, if any, is shown on Your Benefit Schedule.

Doctor
Doctor means a person, other than the Named Insured, a member of the Named Insured's immediate family, or a business associate of the Named Insured, who is duly licensed and practicing medicine in the United States, and who is legally qualified to diagnose and treat Sickness and Injuries. The *Doctor* must be providing services within the scope of his or her license.

Emergency
Emergency means a sudden and unexpected medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the life or health of an individual, or with respect to a pregnant woman, the life or health of the woman or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services
Emergency Services are:

1. Health care services furnished in the emergency department of a Hospital for the treatment of a medical emergency;
2. Ancillary services routinely available to the emergency department of a Hospital for the treatment of a medical emergency; and
3. Emergency medical services transportation.

Experimental/Investigative
Experimental/Investigative means a drug, device or medical care or treatment will be considered *Experimental/ Investigative* if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished;
2. The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigative phase, or if such a consent document is required by law;
3. Either the drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
4. Reliable Evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device, medical care or treatment. Benefits will be considered in accordance with the drug or device at the time it is given or when medical care is received.

We will not limit or deny coverage, or impose additional conditions on the payment of routine patient care costs of items, drugs, and services furnished to a Covered Person in connection with participation in an Approved Clinical Trial. We will not pay for costs of items, services, or drugs that are customarily provided by the sponsors of an Approved Clinical Trial.

Approved clinical trial means:

1. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
   a. The National Institutes of Health;
   b. The Centers for Disease Control and Prevention;

c. The Agency for Health Care Research and Quality;
d. The Centers for Medicare and Medicaid Services;
e. A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
f. The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;

2. A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigative new drug or device application reviewed by the FDA; or
3. An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

Home Health Care Agency
Home Health Care Agency means an entity licensed by state or local law operated primarily to provide skilled nursing care and therapeutic services in an individual's home and:

1. Which maintains clinical records on each patient;
2. Whose services are under the supervision of a Doctor or a licensed graduate registered nurse (RN); and
3. Which maintains operational policies established by a professional group including at least one Doctor and one licensed graduate registered nurse (RN).

Home Health Care Plan
Home Health Care Plan means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Doctor. As part of the plan, an attending Doctor must certify that proper treatment of the Injury or Sickness would require continued confinement in a Hospital in the absence of the services and supplies.

Hospital
A *Hospital* means a short-term, acute general hospital that:

1. Is primarily engaged in providing to inpatients, by or under continuous supervision of Doctors, diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick persons;
2. Has organized departments of medicine and major surgery;
3. Has a requirement that every patient must be under the care of a Doctor or dentist;
4. Provides 24-hour nursing care by or under the supervision of registered nurses (RNs);
5. Has in effect a Hospital review plan applicable to all patients, which meets at least the standards set forth in Section 1861(k) of the United States Public Law 89-97 (42 USCA 1395x(k));
6. Is duly licensed by the agency responsible for licensing such Hospitals; and
7. Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for the treatment of drug addicts or alcoholics, or a place for convalescent, custodial, educational or rehabilitory care.

Hospital Intensive Care Unit
A *Hospital Intensive Care Unit* is a place that:

1. Is a specifically designated area of the Hospital called an Intensive Care Unit that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care;
2. Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
3. Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
4. Is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24-hour basis; and
5. Has a Doctor assigned to the Intensive Care Unit on a full-time basis.

A *Hospital Intensive Care Unit* that meets the definition above may include Hospital units with the following names:

1. Intensive Care Unit
2. Coronary Care Unit
3. Neonatal Intensive Care Unit
4. Pulmonary Care Unit
5. Burn Unit
6. Transplant Unit.

A *Hospital Intensive Care Unit* is NOT any of the following step-down units:

1. Progressive care unit
2. Intermediate care unit
3. Private monitored room
4. Sub-acute Intensive Care Unit
5. Observation Unit; or
6. Any facility not meeting the definition of a *Hospital Intensive Care Unit* as defined in this Policy.

Immediate Family

The Named Insured's Spouse or Domestic Partner, or the parent, brother, sister, child, or grandparent of the Named Insured or Named Insured's Spouse or Domestic Partner.

Injury

Injury means accidental bodily Injury of a Covered Person:

1. Caused by an Accident; and
2. That results in covered loss directly and independently of all other causes.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

Medically Necessary

Medically Necessary means a service or supply that is necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice. A service or supply will not be considered *Medically Necessary* if:

1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. It is Experimental/Investigative treatment.

The fact that a Doctor may prescribe, authorize, or direct a service does not, of itself, make it *Medically Necessary* or covered by the Policy.

Mental or Nervous Disorder

Mental or Nervous Disorder means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind. This does not include a Serious Mental Illness as defined herein.

Mental Health Conditions

Any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual. This does not include a Mental and Nervous Disorder or Serious Mental Illness as defined herein.

Named Insured/You/Your

A *Named Insured* is a person who is a member of an eligible class, as defined on the Benefit Schedule and is covered under the Policy.

Observation Unit

An *Observation Unit* is a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery, or treatment in the emergency room by a Doctor; and which:

1. Is under the direct supervision of a Doctor or registered nurse;
2. Is staffed by nurses assigned specifically to that unit; and
3. Provides care seven Days per week, 24 hours per Day.

Outpatient

Outpatient means a person who incurs medical expenses at Doctor's offices or freestanding clinics, and at Hospitals when not admitted as an Inpatient.

Pre-Existing Condition
Pre-Existing Condition means a condition for which medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received within the 12 months immediately preceding the Effective Date.

Prescription Drug
Prescription Drug means any medical substance, remedy, vaccine, biological product, drug, medication, pharmaceutical or chemical compound, which can only be dispensed pursuant to a prescription and which is required to bear the following statement on the label: "Caution: Federal law prohibits dispensing without a prescription."

Routine Physical Exams
Routine Physical Exams mean the following:
1. A physical examination by a Doctor;
2. Such diagnostic services as may be required as part of such exam;
3. An evaluation of the Covered Person's general health status by his or her primary Doctor. This does not include physical examination and related tests performed in connection with a Covered Person's: (a) employment or prospective employment; (b) school attendance; or (c) application for insurance.

Serious Mental Illness
Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) III-R:
1. Schizophrenia;
2. Paranoid and other psychotic disorders;
3. Bipolar disorders (hypomanic, manic, depressive and mixed);
4. Major depressive disorders (single episode or recurrent);
5. Schizo-affective disorders (bipolar or depressive);
6. Obsessive-compulsive disorders; and
7. Depression in childhood and adolescence.

This does not include a Mental or Nervous Disorder as defined herein.

Sickness
Sickness means an illness, Complications of Pregnancy, Mental or Nervous Disorder, infection, disease or any other abnormal physical condition not caused by an Accident.

Skilled Nursing Facility
Skilled Nursing Facility means a nursing home, licensed as a Skilled Nursing Facility, operating in accordance with the laws of the state in which it is located and meeting all of the following requirements:
1. Is primarily engaged in providing room, board and skilled nursing care for persons recovering from Sickness or Injury;
2. Provides 24-hour a day skilled nursing service under the full-time supervision of a Doctor or graduate registered nurse;
3. Maintains daily clinical records;
4. Has transfer arrangements with a Hospital;
5. Has a utilization review plan in effect;
6. Is not a place for rest, the aged, drug addicts, alcoholics or the mentally ill; and
7. May be a part of a Hospital.

Substance Use Disorder
Substance Use Disorder means alcohol abuse or drug abuse.

Total Disability or Totally Disabled
Total Disability or Totally Disabled means the Named Insured is disabled and prevented from performing the material and substantial duties of his or her occupation. For Dependents, "Totally Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

Urgent Care Facility
Urgent Care Facility means a medical facility separate from a Hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an Injury or Sickness presented on an episodic basis.

Usual, Reasonable and Customary
Usual, Reasonable and Customary means:

1. With respect to fees or charges, fees for medical services or supplies which are:
   a. Usually charged by the provider for the service or supply given; and
   b. The average charged for the service or supply in the locality in which the service or supply is received; whichever is less, or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

In reaching a determination as to what amount should be considered as Usual, Reasonable and Customary for services and supplies, We may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies. The data base used reflects the amounts charged by providers for health care services based on geographic zip code areas generating a statistically credible charge distribution. The data is reflective of reported provider charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the data base.

We/Us/Our/The Company
National Health Insurance Company.

Well Child Care
Well Child Care means periodic Outpatient visits from birth to age 16, which shall include a:

1. History;
2. Physical examination;
3. Developmental assessment;
4. Anticipatory guidance; and
5. Appropriate immunizations and laboratory tests.

Such visits and services shall be in accordance with prevailing medical standards consistent with the "Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics".

ELIGIBILITY AND EFFECTIVE DATE

Certificate Effective Date
A Covered Person's coverage under the Policy begins at 12:01 a.m. Standard Time on the effective date shown on the Benefit Schedule.

Who Is Covered By This Policy
If this is Named Insured coverage as shown on the Benefit Schedule, We insure You, the Named Insured.

If this is Named Insured and Spouse Domestic Partner coverage as shown on the Benefit Schedule, We insure You and Your Spouse Domestic Partner.

If this is family coverage, as shown on the Benefit Schedule, We insure You, Your Spouse Domestic Partner (if applicable), and Your Dependent children.

Spouse Your lawful Spouse, common law Spouse on the day We issue Your Certificate.

Domestic Partner means a person with whom You maintain a committed relationship and who has registered. Each partner must:

1. Be at least 18 years old and competent to contract;
2. Be the sole domestic partner of the other person; and
3. Not be married.

Dependent Children are any natural children, step-children, legally adopted children, children placed into Your custody for adoption including children for whom you are a party in a suit in which the adoption of the child is being sought, or grandchildren if your grandchildren are dependents of Yours for federal income tax purposes at the time of application for coverage of the grandchildren are made; and who are under 26 years of age.

Eligibility
To be eligible to apply for coverage, an individual must:
1. Be between 18 and 64 years of age at the time of enrollment;
2. Be a legal resident of the United States;
3. Not be in full-time service of the Armed Forces;
4. Not be eligible for Medicare;
5. Not be pregnant at the time of the application;
6. Meet the carriers underwriting requirements in force at time of application.

No Covered Person will be eligible for more than one Short Term insurance policy or certificate underwritten by National Health Insurance Company at any one time.

Coverage for the Named Insured's Newborn and Adopted Children
A child of the Named Insured born while this coverage is in force is covered for the first 31 days for the following:
1. Injury and Sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth);
2. Routine newborn care; and
3. Transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition, if such transportation is certified by the attending Doctor as necessary to protect the health and safety of the newborn child. Coverage for such transportation costs may not exceed the Usual Reasonable and Customary Charge, up to $1,000.

We will cover the Named Insured's adopted newborn child(ren) from the moment of birth.

A child adopted by the Named Insured or the Named Insured's insured Spouse or Domestic Partner or a child for whom you are a party in a suit in which the adoption of the child is being sought will automatically become insured as a Dependent. The effective date of such adopted child under the Policy will be the earlier of:
1. The date of placement for the purpose of adoption;
2. The date You become a party in a suit in which the adoption of the child is being sought; or
3. The date on which the Named Insured assumes a legal obligation for total or partial support of the child.

Coverage for adopted children will be to the same extent as provided for other covered Dependent Children.

To maintain coverage in force for each newborn, step child and/or adopted child, the Named Insured must:
1. Notify Us of the birth or placement in the Named Insured's residence within 31 Days of this occurrence;
2. Complete the required application for the child; and
3. Pay the required premium for the child, if any.

If a newborn is not enrolled within 31 Days of birth, coverage will be provided from the date that notice is given. Any additional premium required should be made within 31 Days of notification of birth or placement for the purposes of a step child and/or adoption.

Court Ordered Custody of Children
Coverage is provided to a child in the court ordered custody of the Named Insured on the same basis as a newborn Dependent Child. For each child under court ordered custody, the Named Insured must notify Us within 31 Days of the date on which the court order establishing custody of the child was issued and any additional premiums that are due for the Child must be paid. In order to establish court ordered custody, the Named Insured must send Us a copy of the court order that establishes that the Named Insured has full legal custody of such child.

DESCRIPTION OF BENEFITS

We will pay Covered Expenses due to Injury or Sickness. Covered Expenses, as defined and limited, may be subject to Copays, the Deductible, and Coinsurance Percentage, as shown on the Benefit Schedule. Covered Expenses must be incurred while this coverage is in force, and are subject to the terms, conditions, limitations, exclusions, and maximums stated in the Policy, Certificate and Benefit Schedule.

HOSPITAL COVERED EXPENSES
We will pay Covered Expenses if a Covered Person incurs the following charges for and is Confined in a Hospital for more than 24 hours due to Injuries received in an Accident or due to a Sickness. The Confinement to a Hospital must begin while coverage under the Policy is in force for the Covered Person.

Charges made by a Hospital for:
1. Daily room and board and nursing services not to exceed the average semiprivate room rate;
2. Daily room and board and nursing services in a Hospital Intensive Care Unit;
3. Use of operating, treatment or recovery room;
4. Services and supplies which are routinely provided by the Hospital to persons for use while inpatients;

We will not pay for Confinement of less than 24 hours in a Hospital or routine, post-natal care of a newborn child.

INPATIENT DOCTOR VISITS
We will pay Covered Expenses incurred for treatment provided by a Doctor during a Hospital Confinement.

SURGEON
We will pay for Covered Expenses incurred from a Doctor for surgery. Covered Expenses for an assistant surgeon are covered up to 20% of the Usual, Reasonable and Customary charge of the primary surgeon. Standby availability will not be deemed to be a professional service and therefore is not covered.

ANESTHESIA
We will pay for anesthetics and their administration by a Doctor, subject to the maximum percentage shown on the Benefit Schedule of the benefit payable for the primary surgeon.

EMERGENCY ROOM
We will pay for Emergency treatment of an Injury or Sickness, even if Hospital confinement is not required. However, an additional Deductible, as shown on the Benefit Schedule, will apply to Emergency room charges unless the Covered Person is directly admitted to the Hospital as an inpatient due to that Injury or Sickness.

The Emergency Room Benefit will not cover services rendered by a free-standing Urgent Care Facility or a Hospital-owned Urgent Care Facility.

HEMODIALYSIS
We will pay Covered Expenses incurred for hemodialysis and the charges by the Hospital for processing and administration of blood or blood components; but, not the cost of the actual blood or blood components.

OUTPATIENT HOSPITAL SURGERY
We will pay Covered Expenses for treatment or services in a state-approved freestanding Ambulatory Surgical Center that is not part of a Hospital, or a Hospital Outpatient Surgery Facility

SKILLED NURSING FACILITY
We will pay Covered Expenses in a Skilled Nursing Facility subject to the following:

The Skilled Nursing Facility care must be:
a. Provided in lieu of acute hospitalization; or
b. For the same condition that required a Hospital confinement and the Covered Person must enter the Skilled Nursing Facility within 14 days after discharge from the Hospital after a confinement of at least 3 days.

The maximum benefit for Covered Expenses for Skilled Nursing Facility care is shown on the Benefit Schedule. The maximum daily benefit for confinement in a Skilled Nursing Facility will not exceed one-half of the semi-private Hospital room rate for the Hospital confinement. If not previously Hospital confined, the maximum daily benefit for confinement in a Skilled Nursing Facility will not exceed one-half of the most common semi-private Hospital room rate for the area in which You live. Skilled Nursing Facility care is subject to Pre-authorization as described in the Pre-Authorization Provisions section.

HOME HEALTH CARE
We will pay for treatment of a Covered Person by a Home Health Care Agency under a Home Health Care Plan as shown

on the Benefit Schedule. Up to four (4) consecutive hours in a twenty-four (24) hour period of Home Health Care services shall be considered as one Home Health Care visit. Covered Expenses for Home Health Care are the Usual, Reasonable and Customary charges made for the following:

1. Part-time skilled nursing care;
2. Physical therapy;
3. Speech therapy;
4. Medical supplies, drugs and medicines prescribed by a Doctor;
5. Laboratory services by or on behalf of the Hospital but only to the extent benefits for those services would have been paid under the policy had the Covered Person remained Hospitalized;
6. Occupational therapy; and
7. Respiratory therapy.

However, benefits will not be paid for charges made by a Home Health Care Agency for:

1. Any charges excluded under the Exclusions of the policy;
2. Full-time nursing care at home;
3. Meals delivered to the home;
4. Homemaker services;
5. Any services of an individual who ordinarily resides in Your home or is a member of Your immediate family; or
6. Any transportation services.

Each of the following is considered to be one visit for home health services:

1. A visit by a representative of a home health agency;
2. Four hours of home health aide service; and
3. If home health aide service extends beyond four hours, each additional four hours or portion of that four-hour period.

Benefits for Home Health Care are in lieu of any similar benefits provided under any other provision of the policy.

DOCTOR'S OFFICE VISIT

We will pay for treatment provided by a Doctor in a Doctor's office. For the purposes of this benefit, Covered Expenses include Routine Physical Exams and Well Child Care. Doctor Office visits up to the number of visits shown on the Benefit Schedule will not be subject to Deductible or Coinsurance. Doctor office visits beyond the number of visits shown on the Benefit Schedule are subject to Deductible and Coinsurance.

This benefit is not payable for treatment provided by a member of Your Immediate Family.

URGENT CARE FACILITY VISIT

We will pay for treatment provided in an Urgent Care Facility subject to the Copayment shown on the Benefit Schedule, after which the Coinsurance Percentage will apply. Visits to an Urgent Care Facility are not subject to the Deductible.

DIAGNOSTIC TESTING

We will pay for diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, intelligence, behavioral and educational testing are not included).

The diagnostic test must be performed in a Hospital, Urgent Care Facility, Ambulatory Surgical Center, Doctor's Office, MRI Center, or other properly licensed diagnostic testing center. Interpretation of a diagnostic test is not a Covered Expense.

Diagnostic testing includes the following: MRI; CAT; PET; Colonoscopy; Bone Marrow Test; Stress Test, Laboratory Test, Mammography; EEG; X-Ray; Breast Ultrasound; and Sigmoidoscopy.

MISCELLANEOUS MEDICAL SERVICES AND SUPPLIES

We will pay for dressings, sutures, casts or other supplies which are Medically Necessary and administered by or under the supervision of a Doctor, but excluding nebulizers, oxygen tanks, diabetic supplies, other supplies for use or application at home, and all devices or supplies for repeat use at home, except durable medical equipment. Covered Expenses under this benefit also include artificial limbs, eyes or larynx, breast prosthesis, prosthetic devices, orthotic devices or basic functional artificial limbs including the professional services related to the fitting and use of the device.

Orthotic Device means a custom-fitted or custom-fabricated medical device that is applied to a part or the human body to correct a deformity, improve function, or relieve symptoms of a disease.

The repair or replacement of a functional artificial limb in the event of (i) a pathologic change to the affected post-surgical appendage or site; or (ii) if the Covered Person's functional artificial limb no longer functions properly due to circumstances other than abuse, misuse, or use in a fashion other than as intended by the manufacturer

RECONSTRUCTIVE SURGERY
We will pay for reconstructive surgery when the surgery is directly related to surgery which is covered under the Policy, including Reconstructive Breast Surgery and prosthetic devices incident to a Mastectomy. Coverage will also be extended to include surgery on a non-diseased breast to establish symmetry with the diseased breast.

Coverage for a Medically Necessary mastectomy will include Inpatient care for a Covered Person for a minimum of:
1. 48 hours following a mastectomy; and
2. 24 hours following a lymph node dissection for the treatment of breast cancer, unless the Covered Person and their Doctor agree that a shorter period of time is appropriate.

For purposes of this benefit, the following definitions apply:

Mastectomy means the surgical removal of all or part of a breast as a result of breast cancer.

Reconstructive Breast Surgery means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reductive mammoplasty, mastopexy and all treatment of any physical complications including lymphedemas at all stages of a mastectomy. .

RADIATION THERAPY AND CHEMOTHERAPY
We will pay Covered Expenses incurred for therapeutic treatment of covered benign and malignant conditions, including charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in treatment.

OXYGEN
We will pay for oxygen and other gasses and their administration by or under the supervision of a Doctor.

DENTAL CARE FOR INJURIES
We will pay Covered Expenses incurred for dental treatment and dental surgery necessary to restore or replace natural teeth lost or damaged as a result of an Injury covered under the Policy.

DURABLE MEDICAL EQUIPMENT
We will pay Covered Expenses incurred for Medically Necessary rental of durable medical equipment (limited to a standard basic hospital bed, a portable toilet, and/or a standard basic wheelchair) up to the purchase prices, not including expenses for customization and only for the portion of the cost equivalent to the Coverage Period.

PHYSICAL THERAPY
We will pay Covered Expenses incurred for physical therapy as shown on the Benefit Schedule if prescribed by a Doctor who is not affiliated with the physical therapy practice.

AMBULANCE BENEFIT
We will pay Covered Expenses incurred, as shown on the Benefit Schedule, for ground ambulance transport in connection with Injury or Sickness. The Deductible is waived if the Ambulance transport is due to an Injury or Sickness resulting in inpatient Hospitalization.

ORGAN TRANSPLANT and MARROW RECONSTITUTION or SUPPORT BENEFIT: We will pay up to the maximum transplant benefit as shown on the Benefit Schedule for all Covered Expenses for transplants, combined transplants, and sequential transplants shown on the Benefit Schedule per Coverage Period. The maximum transplant benefit for donor expenses is payable up to the amount shown on the Benefit Schedule per Coverage Period for all transplants and is applied to the maximum transplant benefit. Charges are applied toward the maximum transplant benefit for all Covered Expenses incurred 14 days before a transplant until after a transplant not to exceed the Coverage Period under the Policy. All transplant related benefits apply toward the Maximum Benefit per Coverage Period under the Policy. When generally accepted indications and standards for transplantation are met and all assessments required by the treating institution are successfully completed, Covered Expenses are limited to the following Organ Transplants and Marrow

Reconstitution or Support.

Organ Transplants:

1. Cornea;
2. Heart;
3. Lung;
4. Combined heart/lung;
5. Kidney;
6. Combined kidney/pancreas;
7. Liver (Candidates for liver transplantation must have abstained from alcohol for one year immediately prior to transplantation);
8. Marrow Reconstitution or Support (often called bone marrow transplant or stem cell transplant): A transplantation procedure in which human blood precursor cells are administered to a patient following myelosuppressive or ablative therapy. Such cells may be derived from bone marrow or circulating blood obtained from the patient in an autologous harvest or from a matched donor for an allogenic transplant. The Marrow Reconstitution or Support procedure includes all chemotherapy, the harvesting, and the reinfusion of the marrow or blood precursor cells.

We will not pay for:

1. Multiple organ, tissue and cellular transplants during one operative session, except for a heart/lung.
2. Double lung or simultaneous kidney/pancreas transplant.
3. Any non-human (including animal or mechanical) organ transplant.
4. Transplants approved for a specific medical condition, but applied to another condition.
5. The purchase price of an organ or tissue that is sold rather than donated.
6. Any transplants not listed above.

Transplantation must be authorized in advance by Us. See the Pre-Authorization Provisions section for further direction. No benefits will be paid for any organ, tissue or cellular transplants not reviewed by Us prior to transplant evaluation, testing, preparative treatment or donor search or for transplants which are the result of Sickness or Injury that had its onset prior to the Covered Person's Effective Date.

ACQUIRED BRAIN INJURY

We will pay Covered Expenses incurred for the following services necessary as a result of and related to an Acquired Brain Injury:

1. Cognitive Rehabilitation Therapy;
2. Cognitive Communication Therapy;
3. Neurocognitive Therapy and Rehabilitation;
4. Neurobehavioral, Neurophysiological, Neuropsychological and Psychophysiological Testing or Treatment;
5. Neurofeedback Therapy;
6. Remediation;
7 Post-acute Transition Services; and
8 Community Reintregation Services including Outpatient Day Treatment Services, or other Post-Acute Care Treatment Services.

Coverage includes reasonable expenses related to periodic reevaluation of the care of an Insured Person who has incurred an Acquired Brain Injury, has been unresponsive to treatment and become responsive to treatment at a later date.

For the purposes of this benefit, the following definitions apply:

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital or degenerative. The injury to the brain occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition or psychosocial behavior.

Cognitive Communication Therapy means services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.

Cognitive Rehabilitation Therapy means services designed to address therapeutic cognitive activities, based on an

assessment and understanding of the individual's brain-behavioral deficits.

Community Reintegration Services means services that facilitate the continuum of care as an affected individual transitions into the community.

Neurobehavioral Testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family and others.

Neurobehavioral Treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive Rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive Therapy means services designated to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback Therapy means services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters and that are designed to result in improved mental performance and behavior and stabilized mood.

Neurophysiological testing means an evaluation of the functions of the nervous system.

Neurophysiological treatments mean are interventions that focus on the functions of the nervous system.

Neuropsychological Testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological Treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Outpatient Day Treatment Services means structured services provided to address deficits in physiological behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional, residential, community integration or non-residential treatment settings.

Post-Acute Care Treatment Services means services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-Acute Transition Services means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological Testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological Treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation means the process or processes of restoring or improving a specific function.

AUTISM SPECTRUM DISORDER
We will pay Covered Expenses incurred for a Dependent child from the date of diagnosis until the Dependent child completes nine (9) years of age.

Coverage includes all Generally Recognized Services prescribed in relation to Autism Spectrum Disorder by the Dependent child's Doctor in the treatment plan recommended by that Doctor.

An individual providing treatment prescribed under this Benefit must be a health care Practitioner who is licensed, certified, or registered by any appropriate agency of the state of Texas; whose professional credential is recognized and accepted by an appropriate agency of the United States; or who is certified as a Provider under the TRICARE military health system.

Covered Expenses for Applied Behavior Analysis for a Dependent child 10 years of age or older is covered up to a maximum benefit of $36,000 per Coverage Period.

For purposes of this benefit, the following definitions apply:

Applied Behavior Analysis means the design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. Applied Behavior Analysis includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcers, and other consequences are used to produce the desired behavior change.

Autism spectrum disorder means a neurobiological disorder that includes autism Asperger's syndrome, or Pervasive Developmental Disorder – not otherwise specified.

Generally Recognized Services means services such as:

1. Evaluation and assessment services;
2. Applied behavior analysis;
3. Behavior training and behavior management;
4. Speech therapy;
5. Occupational therapy;
6. Physical therapy; or
7 Medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

CARDIOVASCULAR DISEASE

We will pay Covered Expense incurred for a noninvasive screening test for atherosclerosis and abnormal artery structure and function up to a maximum of $200.00. The noninvasive screening may be either a:

1. Computed tomography (CT) scan that measures coronary artery calcification; or
2. Ultrasonography that measures carotid intima-media thickness and plaque.

The screening must be performed by a laboratory that is certified by a national organization recognized by the Texas Commissioner of Insurance.

To be eligible for this benefit, a Covered Person must be a diabetic or have a risk of developing coronary heart disease based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher, and meet the following age requirements:

1. Males who are older than 45 years of age and younger than 76 years of age; or
2. Females who are older than 55 years of age and younger than 76 years of age.

CHEMICAL DEPENDENCY

We will pay Covered Expenses incurred for treatment, services and supplies when received in connection with Chemical Dependency, including treatment in a Chemical Dependency Treatment Center.

For purposes of this benefit, the following definitions apply:

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Doctor and which facility is also: (1) affiliated with a Hospital under a contractual agreement with an established system for patient referral; or (2) accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or (3) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or (4) licensed, certified, or approved as a chemical

dependency treatment program or center by any other state agency having legal authority to so license, certify, or approved.

CHILD HEARING TEST
We will pay Covered Expenses incurred for treatment for a screening test for hearing loss for a newborn child through the age of 30 days and the necessary diagnostic follow-up care related to the screening test for a newborn child through age 24 months. Covered Expense will not be subject to the Deductible,

CHILD IMMUNIZATIONS
We will pay Covered Expenses incurred for childhood immunizations for each covered child from birth through the date such child is 6 years of age. Coverage for childhood oral and/or injectable immunizations includes immunization against diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus and varicella and any other immunization that is required by law for the child. Covered Expense for immunizations will not be subject to the Deductible, Copay or Coinsurance Percentage provisions of the coverage. However, the Deductible, Copay and Coinsurance Percentage provision will apply to any other service provided at the same time as the immunization.

CLINICAL TRIALS
We will pay Covered Expenses incurred for Routine Patient Care Costs incurred in connection with a Clinical Trial.

For purposes of this benefit, the following definitions apply:

Clinical Trial means a Phase I, Phase II, Phase III or Phase IV clinical trial conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

1. The Centers for Disease Control and Prevention of the United States Department of Health and Human Services; or
2. The National Institute of Health; or
3. The United States Food and Drug Administration; or
4. The United States Department of Defense; or
5. The United States Department of Veterans Affairs; or
6. An institutional review board of an institution in Texas that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Routine Patient Care Costs means costs of any Medically Necessary health care for which benefits are provided under this Group Policy, without regard to whether the Insured is participating in a clinical trial. Routine patient care costs do not include:

1. The cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the Clinical Trial; or
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a Clinical Trial; or
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
4. A cost associated with managing a Clinical Trial; or
5. The cost of a health care service that is specifically excluded from coverage under a health benefit plan.

COLORECTAL CANCER SCREENING
We will pay Covered Expenses incurred for a medically recognized screening examination for the detection of colorectal cancer for Covered Person's age 50 or older and at normal risk for developing colon cancer. This includes:
1. A fecal blood test performed annually; and
2. A flexible sigmoidoscopy performed every five years; or
3. A colonoscopy performed every 10 years.

CRANIOFACIAL ABNORMALITIES (CMJ)
We will pay Covered Expenses incurred for Reconstructive Surgery for Craniofacial Abnormalities of a Covered Dependent child under 18 years of age.

For the purposes of this benefit, the following definition applies:

Reconstructive Surgery for Craniofacial Abnormalities means surgery to improve the function of, or to attempt to

create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease.

DEPENDENT CHILD WITH DEVELOPMENTAL DELAYS
We will pay for Covered Expenses incurred for certain rehabilitative and habilitative therapies for the treatment of a covered Dependent Child with developmental delays in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention. Covered Expenses under this benefit include:

1. Occupational therapy evaluations and services;
2. Physical therapy evaluations and services;
3. Speech therapy evaluations and services; and
4. Dietary or nutritional evaluations.

DIABETES
We will pay Covered Expenses incurred for Diabetes Equipment, Diabetes Supplies, Diabetes Self-management Training, and nutritional counseling for a Covered Person diagnoses with:
1. Insulin dependent or non insulin dependent diabetes;
2. Elevated blood glucose levels induced by pregnancy; or
3. Another medical condition associated with elevated blood glucose levels.

Diabetes Equipment and Supplies means:

1. Blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals;
2. Insulin pumps and associated appurtenances;
3. Insulin infusion devices; and
4. Podiatric appliances for the prevention of complications associated with diabetes.
5. Test strips for blood glucose monitors;
6. Visual reading and urine test strips;
7. Lancets and lancet devices;
8. Insulin and insulin analogs;
9. Injection aids;
10. Syringes;
11. Prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and
12. Glucagon emergency kits.

Coverage shall also include diabetes self-management training prescribed by a Doctor, including Medically Necessary medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding programs whose only purpose is weight reduction) only if that therapy is provided by a licensed health care professional with specialized training in diabetes management, including a licensed registered dietician or a licensed certified nutritionist, and that is limited to the following:
1. Visits upon the diagnosis of diabetes;
2. Medically Necessary changes in a Covered Person's self-management based on a Doctor's diagnosis representing a significant change in the Covered Person's symptoms or condition; and
3. Visits for Medically Necessary re-education or refresher training.

Coverage shall also be provided for:
1. Office visits and consultations with Doctors and practitioners for monitoring and treatment of diabetes, including office visits and consultations with appropriate specialists;

2. Immunizations required by Insurance Code Article 21.53F, Coverage for Childhood Immunizations;
3. Immunizations for influenza and pneumococcus;
4. Iinpatient services, and Doctor and practitioner services when the Covered Person is confined to a Hospital, rehabilitation facility, or a skilled nursing facility; and E. Inpatient and outpatient laboratory and diagnostic imaging services.

FORMULAS NECESSARY TO TREAT PHENYLKETONURIA OR A HERITABLE DISEASE
We will pay Covered Expenses incurred for formulas necessary to treat Phenylketonuria or a Heritable Disease.

For the purposes of this Benefit, the following definitions apply:

Heritable Disease means an inherited disease that may result in mental or physical retardation or death.

Phenylketonuria means an inherited condition that, if not treated, may cause severe mental retardation.

MAMMOGRAPHY
We will pay Covered Expenses incurred for one baseline mammogram for a female Covered Person 35 years of age or older. This benefit is not subject to satisfaction of the Deductible.

PAPILLOMAVIRUS AND CERVICAL CANCER TESTING
We will pay Covered Expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer for female Covered Persons age 18 and older. Coverage includes a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus. This benefit is not subject to satisfaction of the Deductible.

MENTAL ILLNESS AND EMOTIONAL DISORDER BENEFIT
We will pay Covered Expenses incurred for Mental or Nervous Disorders when a Covered Person receives necessary care and treatment for such disorders in a Hospital or Psychiatric Day Treatment Facility which is accredited by the Program for Psychiatric Facilities, its successor, or the Joint Commission on Accreditation of Hospitals provided, however, that:

1. Treatment in such facility shall not exceed eight (8) hours in any 24-hour period;
2. Each full day of treatment in such facility shall be considered equal to one-half day of Hospital Confinement; and
3. The attending Physician certifies that such treatment is in lieu of Hospital Confinement.

Coverage will also be provided for treatment rendered in a Crisis Stabilization unit or a Residential Treatment Center for Children and Adolescents. Benefit for such treatment will be paid on the same basis as Hospital Confinement, subject to the following:

1. Treatment must be based on an Individual Treatment Plan;
2. Treatment must be provided in state licensed or certified facilities;
3. The Covered Person has a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a Hospital if care and treatment were not provided in the Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents.

For purposes of benefit payment, two days of treatment in a Crisis Stabilization Unit or Residential Treatment Center for children and adolescents will equal one day of treatment in a Hospital.

For purposes of this benefit the following definitions apply:

Crisis Stabilization Unit means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to person who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Individual Treatment Plan means a treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Residential Treatment Center for Children and Adolescents means a child-care institution that provides residential care and treatment for emotionally disturbed children and Adolescents and that is accredited as a Residential Treatment Center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

OSTEOPOROSIS
We will pay Covered Expenses incurred for bone mass measurement to determine a risk of osteoporosis and fractures associated with osteoporosis for a Qualified Covered Person.

For purposes of this benefit, the following definition applies:

Qualified Covered Person means:

1. Postmenopausal woman who is not receiving estrogen replacement therapy;
2. An individual with (1) vertebral abnormalities; (2) primary hyperparathyroidis; or (3) a history of bone fractures; and
3. An individual who is: (1) receiving long-term glucocorticoid (steroid) therapy; or (2) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

PROSTATE ANTIGEN TEST
We will pay Covered Expenses incurred for one Prostate Antigen Test (PSA) for a male Covered Person 50 years of age or older or a male Covered Person age 40 with a family history of prostate cancer or a prostate risk factor. This benefit is not subject to any dollar limits.

SERIOUS MENTAL ILLNESS
We will pay Covered Expenses incurred as shown on the Benefit Schedule for treatment, services, or supplies in connection with a Serious Mental Illness, except Serious Mental Illness resulting from: addiction to a controlled substance or marijuana that is used in violation of the law; or mental illness resulting from the use of a controlled substance or marijuana in violation of the law, if received:

1. While Confined in a Hospital; or
2. On a group or individual outpatient basis at the following facilities in lieu of a Hospital Confinement, as certified by the Doctor:
   a. Psychiatric Day Treatment Facility. The facility must be accredited by the Program of Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Hospitals. Treatment must be for not more than eight hours in any 24 hour period.
   b. Residential treatment center for children and adolescents. The facility must be accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.
   c. A crisis stabilization unit.

SPEECH AND HEARING BENEFIT
We will pay Covered Expenses incurred for the necessary care and treatment of loss or impairment of speech or hearing the same as any other Sickness, subject to the same Deductibles, and Coinsurance Percentage.

TELEMEDICINE AND TELEHEALTH
We will pay Covered Expenses incurred for telehealth services and telemedicine medical services.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)
We will pay Covered Expenses incurred for treatment of temporomandibular, joint dysfunction, including the jaw, or craniomandibular joint dysfunction resulting from Injury, trauma, congenital defect, or developmental defect or pathology on the same basis as any other Injury. Benefits are not provided for dental services. Treatment, when under the order of the attending Doctor with concurrence of the attending dentist, will include that which is performed in a Hospital or surgical center for a Covered Person due to documented physical, mental, or medical reason.

AMINO ACID-BAED ELEMENTAL FORMULAS
We will pay Covered Expenses incurred for amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of:

a. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
b. Severe food protein-induced enterocolitis syndrome;
c. Eosinophilic disorders, as evidenced by the results of a biopsy; and
d. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Provided, the treating Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary for the treatment of an Insured Person who is diagnosed with a disease or disorder listed above.

Covered Expenses include any Medically Necessary services associated with the administration of the formula.

ORALLY ADMINISTERED ANTICANCER MEDICATION
We will pay Covered Expenses incurred for prescribed orally administered anticancer medication that is used to kill or slow the growth of cancerous cells on the same basis as intravenously administered or injected cancer medications covered under this Policy.

PRE-AUTHORIZATION

We review proposed and rendered health services to determine whether the services are or were Medically Necessary or Experimental or Investigative. This process is called Preauthorization.

All determinations that services are not Medically Necessary will be made by licensed Doctors.

In order to obtain pre-authorization of a service, call the toll free number on Your identification (ID) card to obtain Our authorization of the services listed below. We will review the proposed medical care with You and Your Doctor to determine the appropriateness of treatment and to assist You with discharge needs. We will notify You and Your Doctor of the outcome of Our review. Refer to the Reduction of Payment provision below to determine how Your benefits will be reduced if Our authorization is not obtained.

Before You call Us, have the following information on hand:

1. Your social security number; or the patient's social security number, if different from Yours; and
2. Your Benefit Schedule number; and
3. The Doctor's name and telephone number; and
4. The procedure and/or diagnosis; and
5. The proposed date of admission or date the procedure will be performed; and
6. The facility's name and phone number.

Contact Us for pre-authorization of the following services:

Non-Emergency Confinements: Call at least 7 business days prior to an inpatient stay in a Hospital. A Non-Emergency Confinement is an inpatient stay for a Sickness or Injury that is not immediately life-threatening but is Medically Necessary.

Emergency Confinements: Call within 24 hours (excluding Saturdays, Sundays and legal holidays), or as soon as reasonably possible, after an inpatient admission for Emergency treatment.

Organ Transplant or Marrow Reconstitution or Support: Call prior to any transplant evaluation, testing, preparative treatment or donor search.

Skilled Nursing Facility Confinements: Call at least 7 business days prior to Your admission.

Inpatient Rehabilitation Programs: Call at least 7 business days prior to Your admission.

Outpatient Physical Medicine: Call at least 7 business days prior to receiving any services.

Outpatient or Day Surgery Procedures: Call at least 7 business days prior to a scheduled outpatient procedure. Authorization is not required for: magnetic resonance imaging (MRI); computerized axial tomography (CAT) scan; ultrasound testing; an emergency room visit; or an office visit to a Doctor unless surgery is performed.

Home Health Care: Call at least 7 business days prior to receiving any services.

Durable Medical Equipment: Call at least 7 business days prior to obtaining the equipment if the purchase or rental price per month is more than $500.

Dental Procedures Performed in a Hospital or Free-Standing Ambulatory Surgical Facility: Call at least 7 business days prior to receiving any services.

The review process must be repeated if treatment is received more than 30 days after Our review or if the type of treatment, admitting Doctor or facility differs from what We authorized. **NOTE:** That portion of a Confinement that exceeds the number of authorized days will be considered unauthorized, unless an extension is granted. To receive an extension, the Doctor must call Us at least 24 hours prior to the originally scheduled discharge date and request an extension. We may or may not authorize an extension. Benefits will be reduced for unauthorized extensions per the Reduction of Payment provision below.

REDUCTION OF PAYMENT: These authorization requirements are included to assist a Covered Person in obtaining the most appropriate medical care. Follow the requirements described above so You can receive the full benefits of coverage under the Policy. If You do not obtain authorization for the services listed above or if the course of treatment is not performed in the manner authorized, Your benefits will be reduced for otherwise Covered Expenses by the amount shown on the Benefit Schedule. The reduced amount, or any portion thereof, will not be applied to any Deductible or Out-of-Pocket Maximum determination.

In addition, NO benefits will be paid for expenses:

1. That are not for Medically Necessary services; or
2. That are otherwise not considered a Covered Expense; or
3. For Organ Transplant or Marrow Reconstitution or Support if the procedure was not authorized prior to the beginning of the transplant evaluation, testing, preparative treatment or donor search.

AN AUTHORIZATION IS NOT THE SAME AS "VERIFICATION OF BENEFITS" AND DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID. AUTHORIZATION ADDRESSES ONLY THE MEDICAL NECESSITY AND APPROPRIATENESS OF THE CARE TO BE RECEIVED, INCLUDING THE TYPE OF TREATMENT AND FACILITY. PAYMENT OF BENEFITS IS SUBJECT TO ALL THE TERMS, LIMITS, AND CONDITIONS IN THE POLICY, CERTIFICATE AND BENEFIT SCHEDULE.

LIMITATIONS AND EXCLUSIONS

Except as specifically provided for in the Policy, Certificate and Benefit Schedule or any attached Riders, We will not pay benefits for Sickness or Injuries that are caused by or expenses incurred for:

1. Intentionally self-inflicted Sickness or Injury, whether sane or insane.
2. Sickness or Injury to the extent that benefits are paid by Medicare or any other government law or program, except Medicaid (Medi-Cal in California); or medical coverage under any automobile or no fault insurance.
3. Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when You do not file a claim for benefits.
4. Treatment of Sickness or Injury caused by or contributed to by war or any act of war; or participation in the military service of any country. Any premium paid for a time not covered will be returned pro-rata.
5. Dental treatment unless a Hospital stay is required due to Injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient Hospital care must be the least expensive setting needed to produce a professionally adequate result and the Hospital charges only are Covered Expense. The treatment must be received while the Covered Person's coverage under the Policy is in force.
6. Eyeglasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.
7. Normal pregnancy or childbirth; routine well baby care including Hospital nursery charges at birth; or abortion, except for Complications of Pregnancy, as defined herein.
8. Infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization.
9. Genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing.
10. Sex transformation; treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire.
11. Treatment and medication to stimulate growth and growth hormones for any purpose.
12. Treatment, services or supplies to address quality of life or lifestyle concerns including, but not limited to: smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.
13. Sterilization and drugs or devices used directly or indirectly to promote or prevent conception.
14. Weight reduction or weight control programs or treatment; or surgery for weight control, obesity or morbid obesity.
15. All treatments for varicose veins.
16. Therapy or treatment for learning disorders or disabilities, except as provided in the Benefits section for developmental delays.
17. Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations, or case management fees.
18. Cosmetic treatment or reconstructive or plastic surgery that is primarily a cosmetic procedure, including medical or surgical complications arising therefrom, except as provided in the Benefits section.
19. Treatment of Mental Health Conditions, Substance Use Disorders; and Outpatient treatment of Mental and

Nervous Disorders, except as specifically covered.

20. Treatment or services rendered by, or supplies purchased from, a member of Your Immediate Family or an employer.
21. Treatment or services required due to accidental Injury sustained in operating a motor vehicle while the Insured's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not the Injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not the Covered Person is charged with any violation in connection with the accident.
22. Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity, including the following: Participating, instructing, demonstrating, guiding or accompanying others in parachute jumping, hang-gliding, bungee jumping, flight in an aircraft other than a regularly scheduled flight by an airline, racing any motorized or non-motorized vehicle, rock or mountain climbing, professional or semi-professional contact sports of any kind. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.
23. Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received, including the following: Participating, instructing, demonstrating, guiding or accompanying others in skiing and horse riding. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.
24. Treatment or services required due to Injury sustained while participating in any interscholastic or inter-collegiate sport, contest or competition or while practicing, exercising, undergoing conditioning or physical preparation for any such sport, contest or competition.
25. Treatment or services required for Sickness or Injury resulting from being intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the Sickness or Injury took place.
26. Expense incurred due to Sickness or Injury of which a contributing cause was the Covered Person's voluntary attempt to commit, participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person's being under the influence of illegal narcotics or non-prescribed controlled substances.
27. Custodial Care; respite care; rest care; or supportive care.
28. Expenses incurred outside of the United States or its possessions or Canada.
29. Expenses incurred for Experimental or Investigational Treatment, subject to the Pre-authorization section.
30. Private duty nursing services rendered during Hospital confinement and charges for standby Health Care Practitioners.
31. Dental braces, dental appliances, corrective shoes, repairs to or replacement of prosthetic devices, or orthotics, except as provided in the Benefits section.
32. Reduction mammoplasty; revision of breast surgery for capsular contraction or replacement of prosthesis, except as provided in the Benefits section.
33. Services or supplies for foot care, including care of corns, bunions or calluses, except capsular or bone surgery.
34. Treatment, services or supplies rendered or received when coverage under the Policy is not in effect, except as provided under the Extension of Benefits provision.
35. Any amount in excess of the Usual, Reasonable and Customary Amount as determined by Us under the Policy.
36. Prophylactic treatment or services. Prophylactic means any surgery or other procedure performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
37. Treatment, services or supplies that are not Medically Necessary as determined by Us under the Policy.
38. Treatment, services or supplies that are prescribed, provided or furnished in a manner primarily for the convenience of the Covered Person or Doctor.
39. Treatment, services or supplies not described in the Benefits section.
40. Expenses for marital counseling or social counseling.
41. Outpatient Prescription Drugs, medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor except as provided in the Benefits section for diabetes.
42. Treatment, services or supplies provided at no cost to the Covered Person.
43. Telephone consultations except as specifically covered or failure to keep a scheduled appointment.
44. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.
45. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
46. Treatment for cataracts.
47. Treatment of the temporomandibular joint unless Medically Necessary and caused by a congenital or

developmental deformity, Sickness or Injury and except as specifically covered.
48. Biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy, except as provided in the Benefits section for acquired brain injury.
49. Orthoptics and visual eye training.
50. Hypnotherapy when used to treat conditions that are not recognized as Mental and Nervous Disorders by the American Psychiatric Association, and biofeedback, and nonmedical self-care or self-help programs.
51. Any services or supplies in connection with cigarette smoking cessation.
52. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive materials.
53. Treatment for or related to any congenital condition, except as it relates to a newborn or adopted child added as a Covered Person to the Policy and as provided in the Benefits section for reconstructive surgery for craniofacial abnormalities and temporomandibular joint disorder
54. Spinal manipulation or adjustment.
55. Sclerotherapy for veins of the extremities.
56. Chronic fatigue or pain disorders; or immunodeficiency disorders.
57. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
58. Kidney or end stage renal disease.
59. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.
60. Hospice care.
61. Costs of services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops, except as specifically covered.
62. Expenses for surgery during the first 6 months after the Effective Date of Coverage for a Covered Person for a total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis or carcinoma (subject to all other coverage provisions, including but not limited to, the Pre-Existing Conditions exclusion); tonsillectomy, adenoidectomy, repair of deviated nasal septum or any type of surgery involving the sinus, myringotomy, tympanotomy, herniorraphy, or cholecystectomies.

Pre-Existing Condition Exclusion
Charges resulting directly or indirectly from a Pre-Existing Condition are excluded from coverage hereunder.

This exclusion does not apply to a newborn or newly adopted child who is added in accordance with the **ELIGIBILITY AND EFFECTIVE DATE** section.

This exclusion also does not apply to routine follow-up care for breast cancer to determine whether a breast cancer has recurred in a Covered Person who has been previously diagnosed with breast cancer, unless evidence of breast cancer is found during or as a result of follow-up care.

TERMINATION OF INSURANCE

Termination of a Named Insured's Coverage
The coverage of a Named Insured will terminate on the earliest of the following dates:
1. The date the Policy terminates;
2. The last day of the month in which the Named Insured reaches the age of 65.;
3. Midnight on the last day of the grace period;
4. 90 days after the date written notice was provided that the Named Insured is no longer in an eligible class
5. The date the Named Insured's class is no longer included for insurance
6. The date the Named Insured asks Us to end their coverage;
7. The date the Named Insured dies;
8. The end of the Coverage Period;
9. The date a Covered Person receives the Coverage Period Maximum Benefit Amount; or
10. The date the Covered Person enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less.

At the death of the Named Insured, all rights and privileges as a Named Insured under the policy will transfer to the surviving Dependent Spouse or Domestic Partner. The Dependent Spouse or Domestic Partner will then be considered the Named Insured instead of a Dependent. In the event the Dependent Spouse or Domestic Partner remarries, coverage under the Policy for the Dependent Spouse or Domestic Partner and Dependent Child(ren), if any, will end on the first day

of the month following the date of that marriage. If there is no surviving Dependent Spouse or Domestic Partner, or at the death of a surviving Dependent Spouse or Domestic Partner, all rights and privileges as a Named Insured under the Policy will transfer to each Dependent Child, if any, and he will be considered the Named Insured instead of a Dependent.

Extension of Benefits
If a Covered Person is Totally Disabled as a result of Sickness or Injury, and received treatment for such condition while his or her coverage under the Policy was in force, We will pay benefits for that Sickness or Injury, subject to the applicable limits shown on the Benefit Schedule. The extension of benefits terminates on the earliest of the following:

1. The end of treatment for the Sickness or Injury that caused the Total Disability;
2. The date the Total Disability ends;
3. The end of the 90 days following the date coverage terminated;
4. The date the Covered Person becomes eligible for any other insurance plan providing coverage for the same conditions causing the Total Disability; or
5. The date the Coverage Period Maximum Benefit amount has been reached.

No payment will be made under this provision beyond 90 days from the date of termination of coverage.

When Coverage Ends on the Named Insured's Spouse or Domestic Partner and/or Dependents
If this is Named Insured and Spouse or Domestic Partner coverage or two-parent family coverage, coverage on the Named Insured's Spouse or Domestic Partner will end:

1. The last day of the month in which the Named Insured's Spouse or Domestic Partner reaches the age of 65 or becomes eligible for Medicare;
2. If the premiums are not paid for the Named Insured's Spouse or Domestic Partner when they are due;
3. On the date the Named Insured asks Us to end their Spouse's or Domestic Partner's coverage;
4. On the date the Named Insured's coverage terminates; or
5. On the date the next premium is due after the Named Insured divorces their Spouse or terminates the Domestic Partnership.

If this is family coverage, coverage on the Named Insured's Dependents will end:

1. If the premium is not paid for the Named Insured's Dependents when it is due;
2. On the date the Named Insured asks Us to end their Dependent coverage; or
3. On the date the Named Insured's coverage terminates.

Coverage will end on each Dependent Child when they no longer qualify as a Dependent as defined in the Policy. It is the Named Insured's responsibility to notify Us if any Dependent no longer qualifies as an eligible Dependent. If this is family coverage and all of the Dependents no longer qualify as eligible Dependents and We are not notified, the extent of Our liability will be to refund premium for the time period for which they did not qualify. Coverage will not end on a Dependent Child who reaches the limiting age if that child is incapable of self-sustaining employment by reason of developmental disability, mental disability or physical handicap and who became so incapable prior to the attainment of the age at which Dependent coverage would otherwise terminate and who is dependent upon such Named Insured for support and maintenance. Proof of the disability and/or dependency must be furnished to Us within 31 days of the Child's attainment of the limiting age and subsequently, as may be required by Us. However, proof may not be required more often than annually after the first 2 years following the Dependent Child's attainment of the limiting age.

COORDINATION OF BENEFITS (COB)

Some people have health care coverage through more than one medical insurance plan at the same time. COB allows these plans to work together so the total amount of all benefits will never be more than 100 percent of the allowable expenses during any coverage year. This helps to hold down the costs of health coverage.

COB does not apply to life insurance or accidental death and dismemberment benefits.

The term "plan" applies separately to each policy, contract agreement or other arrangements for benefits or services. The term "plan" also applies separately to that part of any policy, contract, agreement or other arrangements for benefits or services that coordinates its benefits with other plans and to that part that does not.

When a plan provides benefits in the form of services rather than cash payment the reasonable cash value of each service rendered will be considered to be both: (1) an allowable expense; and (2) a benefit paid.

Definitions. "Plan" – means any of the following which provides benefits or services for medical expenses:

1. Individual or family insurance or subscriber contracts.
2. Any group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage.
3. Any federal, state or local governmental programs, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

Each contract or other arrangement for coverage under the above paragraphs is a separate plan. Also, if an arrangement has two parts and COB rules apply to one of the two, each of the parts is construed to mean a separate Plan.

The term "plan" does not include:

1. School accident-type coverages. (These contracts cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a to-and-from school basis);
2. Hospital indemnity benefits;
3. Excess insurance policies;
4. Policies with coverage limited to specified illnesses or accidents;
5. Medicare Supplement policies;
6. A state plan under Medicaid.

"Primary Plan (Primary)" – means the Plan which determines its benefits before those of the other Plan. When there are more than two (2) Plans, This Plan may be Primary as to one and Secondary as to another.

"Secondary Plan (Secondary)" – means the Plan which determines its benefits after those of the other Plan. When there are more than 2 Plans, This Plan may be Secondary as to one and Primary as to another.

"This Plan" – means the benefits provided under the group policy.

Effect on Benefits. Plans use COB to decide which plan should pay first for a covered expense. If the Primary Plan's payment is less than the charge for the allowable expense, then the Secondary Plan will apply its benefit payment to the balance.

The following rules will be used to establish the order of benefit determination:

1. A plan which does not have a COB provision will always be the Primary Plan.
2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
   a. First, benefits of a plan covering persons as an employee, member, or subscriber.
   b. Second, benefits of a plan of an active worker covering persons as a dependent.
   c. Third, Medicare benefits.
3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
   a. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.
   b. If both parents have the same birthday the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
   c. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
   d. When the parents are separated or divorced and the parent with custody has not remarried the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

e. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
f. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.

4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a plan that covers that person as a laid off or retired primary insured or as that primary insured's dependent. This rule will not apply if the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits.
5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
   a. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
   b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. When rules 2 through 5 do not establish an order of benefit determination the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

Facility of Payment. If another plan makes a benefit payment that should have been made by Us We have the right to pay the other plan any amount We deem necessary to satisfy Our obligation under these COB rules.

Right of Recovery. If the amount of Our benefit payment is more than the amount needed to satisfy Our obligation under these COB rules, We have the right to recover the excess amount from:

1. Any persons to or for whom, or with respect to whom, the payments were made;
2. Any insurance companies; or
3. Any other organizations.

Right to Receive and Release Necessary Information. In order to carry out these COB rules:

1. We have the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as We deem necessary; and
2. Any person claiming benefits under this plan must give Us any information necessary to carry out this provision.

PREMIUMS

When and Where to Pay Premiums
The premiums for the coverage must be paid to Us at Our home office when they are due. The premium due dates are based on:

1. The effective date of the coverage shown on the Benefit Schedule; and
2. The premium frequency.

The *premium frequency* is how often the premiums are paid.

Grace Period (If Premiums Are Not Paid When Due)
After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the grace period. If the premium is not paid before the grace period ends, coverage will terminate at midnight on the last day of the grace period.

Our Right to Change Premiums
We have the right to change the premium We charge. If We plan to make a change, We will send You a notice at least 60 days before We make it.

We may change premium rates at any time for reasons which affect the risk assumed, including but not limited to the

reasons shown below:

1. A change occurs in the plan design;
2. The Named Insured moves or changes his/her address; or
3. A new law or a change in any existing law is enacted which applies to this plan.

GENERAL PROVISIONS

Entire Contract: Changes
The Policy is a legal contract between the Policy Holder and Us. Your coverage under the Policy is issued in consideration of Your application and payments, called premiums.

Whenever We use the word Policy, We mean the entire contract. The entire contact consists of:

1. The Policyholder's application and the Policy, including the Certificate and Benefit Schedule;
2. The copy of the Named Insured's application; and
3. Any attached riders or endorsements.

Riders and endorsements add provisions to or change the terms of the Policy.

Any changes made to the Policy or this Certificate must be attached in writing and signed by one of Our executive officers at Our home office. No agent or anyone else can change the Policy or this Certificate or waive any of its provisions.

Incontestability
Any statement made by the Named Insured, except for fraudulent misstatements, is considered a representation and not a warranty. A copy of the statement will be provided to the Named Insured or whoever made the statement. No statement will be used to contest, the validity of coverage under the Policy unless it is in writing, signed by the Named Insured.

Coverage Provided by this Policy
We insure a Covered Person for loss according to the provisions of this Policy.

Conformity with State Statutes
If any provision of the Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

Misstatement of Age and Sex
If the age or sex of a person covered under the Policy has been misstated, We will make an equitable adjustment of the premium. Such premium will be the difference between the premiums paid and the premiums which would have been paid at the Covered Person's true age or sex, whichever applies. If coverage would not have been issued, We will refund the premiums paid for such insurance.

Non-Renewability of Insurance: Insurance for a Covered Person does not renew and shall terminate at the end of the Coverage Period selected by the Named Insured and approved by Us, unless earlier terminated as provided in the policy and this certificate.

HOW TO FILE A CLAIM/CLAIM PROVISIONS

Notice of Claim
Written notice of claim must be given to Us as soon as possible. Written notice of claim given by or on behalf of the Insured to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms
After receiving notice of claim, claim forms will be given for filing a claim. If such forms are not given within 15 days after receipt of such notice, the claimant will be deemed to have complied with the requirements of the Policy by submitting written proof covering the nature and extent of loss for which claim is made to Us within the time stated under the Proof of Loss provision.

Proof of Loss
The Named Insured must give Us a written proof of loss within 90 days after the covered loss begins. If he is not able to

give Us written proof of loss within 90 days, it will not have a bearing on this claim if proof is given to Us as soon as it is reasonably possible, except in the absence of legal capacity.

Payment of Claim
Benefits will be paid to the Named Insured or to the Named Insured's designated beneficiary on record. If the Named Insured is deceased and no named beneficiary is on record with Us, all or any part of the benefits owed will be paid to the Named Insured's estate. In lieu of paying benefits to the estate, We may, at Our option, pay benefits, up to an amount not exceeding $5,000 to any one or more of the following surviving relatives:

1. Spouse or Domestic Partner;
2. Parent;
3. Child or children; and
4. Brothers or sisters.

If there are no survivors in any of these classes, We may pay benefits for expenses to a Hospital or Doctor or other person actually supporting the Named Insured and who is deemed by Us to be entitled to payment. Any payments made in good faith will end Our liability to the extent of the payment.

We will pay to the Texas Department of Human Services, any amounts which would have been paid to the Named Insured but were paid by the Department through the Medical Assistance Act of 1967, as amended.

Covered Expenses payable on behalf of a Covered Dependent child will be paid to the Texas Department of Human Services upon written notification if: a) the Named Insured has possession or access to the child by court order or is not entitled to possession or access to the child and is required by court order to pay child support; b) the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 and 32 of the Texas Human Resources Code; and c) notification is given in writing attached to the first submitted claim that such claim reimbursement should be paid to the Texas Department of Human Services.

For a covered Dependent child, reimbursement may be made on behalf of that child to a person who is named managing conservator by court order issued by a court of competent jurisdiction of any state. The managing conservator must submit to Us: a) a proper claim form; b) written notice naming the conservator; and c) certified copy of court order or other evidence allowed by rule of the State Department of Insurance. This paragraph will not apply when a valid assignment of benefits has been exercised or to claims submitted by the Named Insured where the Named Insured has paid any portion of a medical bill that would be covered under the terms of the Policy.

Time of Payment of Claim
We will pay any benefits due not more than 60 days after We receive written proof of loss.

Physical Examinations and Autopsy
We can require that any Covered Person be examined by a Doctor of Our choice at Our expense as often as it is reasonably necessary while a claim is pending. We have the right and opportunity to make an autopsy in the case of death where it is not prohibited by law.

Third Party Liability
No benefits are payable for any Sickness or Injury for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, the Company will advance the benefits of this Policy to the Named Insured subject to the following:

1. The Named Insured agrees to advise Us, in writing, within 60 days of any Covered Person's claim against the third party and to take such action, provide such information and assistance, and execute such paper as We may require to facilitate enforcement of the claim. The Named Insured and Covered Person also agree to take no action that may prejudice Our rights or interests under this policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice Our rights or interests, will be material breach of this Policy and will result in the Covered Person being personally responsible for reimbursing Us.
2. We will automatically have a lien, to the extent of benefits advanced, upon any recovery that any Covered Person receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this Policy for the treatment of the Sickness, or Injury for which the third party is liable.

Legal Action
We cannot be sued for benefits under this Policy until 60 days after written proof of loss has been given as required by the Policy or until after the expiration of 3 years from the time We receive written proof of loss.

Rescission
If We determine that there was fraud or intentional misrepresentation of a material fact that caused Us to issue coverage when coverage would not have been issued had there been no fraud or intentional misrepresentation of a material fact, We may rescind coverage. If the fraud or intentional misrepresentation of a material fact pertained to the Covered Person, coverage may be rescinded for the Covered Person and all Dependents including Spouses. Rescission causes coverage to be terminated back to the Effective Date as if the coverage were never issued.

Rescission will result in denial of all claims submitted. If rescission occurs, We will refund premiums received for any coverage We rescind within a reasonable time of the rescission; however, We will subtract total Claim payments for the person whose coverage We rescinded from this premium refund. If we have paid Claims in excess of the amount of premium We received for the person whose coverage We rescinded, We have the right to obtain a refund from the Covered Person.

APPEALS OF CLAIMS PAYMENT DECISIONS
For the purposes of this section, any reference to "You"', "Your", or Covered Person also refers to a representative or provider designated by you to act on Your behalf, unless otherwise noted.

Definitions:

Grievance means a written complaint or oral complaint if the complaint involves an urgent care request submitted by or on behalf of a Covered Person regarding:

- Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to Utilization Review;
- Claims payment, handling or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a Covered Person and a health carrier.

Adverse Determination means:
- A determination by a health carrier or Our designee Utilization Review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a Covered Person's eligibility to participate in the health carrier's health benefit plan; or
- A rescission of coverage determination.

There is one level of appeal for coverage decisions. To initiate an appeal, You must submit a request for an appeal in writing. We will acknowledge receipt of your appeal or grievance within seventy-two (72) hours. You should state the reason why You feel your appeal or grievance should be approved and include any information supporting your appeal. If You are unable or choose not to write, You may ask to register Your appeal by telephone. Call the number for Claims or Customer Service as shown on Your identification card or write to us at the address below:

Claims & Appeals Department
National Health Insurance Company
P.O. Box 27267, Minneapolis MN 55427-0267

INTERNAL APPEAL REVIEW

If You are not satisfied with an administrative, eligibility, rescission of coverage, denial or reduction of benefit or a health care determination for pre-service, or current care coverage determination decision, You or Your appointed representative has the right to file an appeal or a grievance no later than 2 years from the date of denial.

Your appeal will be reviewed and the decision will be made by someone not involved in the initial decision. Appeals involving Medical Necessity, clinical appropriateness, or experimental and investigational will be considered by a health care professional.

We will respond in writing with a decision within (15) fifteen calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within (30) thirty calendar days after we receive an Appeal for a post-service coverage determination. If more time or information is needed to make the determination, we will notify You in writing or electronically to request an extension of up to fifteen (15) calendar days and to specify any additional information needed to complete the review. If the denial is upheld, we will deem the internal appeals process to be exhausted and You may request an External Review if applicable. External Review is only available for Adverse Determinations. For non-adverse benefit decisions, you may contact the Texas Department of Insurance as indicated on Your Important Notice that was provided with your Policy. We or Our designee Utilization Review organization will send You with the final adverse determination the information for requesting an External Review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health, ability to regain maximum function or in the opinion of Your Physician would cause you severe pain which cannot be managed without the requested services; (2) or Your appeal involves non-authorization of an admission or continuing inpatient stay. Our Medical Review Agent in consultation with the treating Physician, will decide if an expedited review is necessary. When an Appeal is expedited, we will respond within one working day from the date all information necessary to complete the appeal is received.

RIGHT TO EXTERNAL REVIEW

If You are not satisfied with the final adverse benefit determination decision of the internal appeal review regarding your Medical Necessity, clinical appropriateness, health care setting, level of care, effectiveness of a covered benefit, whether a treatment is an experimental or investigational issue, or any other matter that involves medical judgment, you have the right to an External Review. The External Review Process allows for an independent, outside review of adverse benefit determinations by health plans.

Adverse benefit decisions mean the plan decided against Your request to authorize care or they refuse to pay for services already performed. A decision to use this external level of appeal will not affect Your rights to any other benefits under the plan.

There is no charge for You to initiate this External Review process. We will abide by the decision of the state.

Standard External Review

You may submit a standard external review request via mail for an external review after the date You received the final internal adverse benefit determination notice.

Provide all necessary paperwork and information to the address provided in the final Adverse Determination notification.

Expedited External Review
In some cases, You may ask for an expedited (faster than usual) external review. An expedited review may be requested when:

1. You have asked for an expedited internal appeal and wants an expedited external review at the same time, and the timeframe for an expedited internal appeal (72 hours) would place Your life, health or ability to regain maximum function in danger;

OR

2. You completed an internal appeal with the plan and the decision was not in Your favor, and:
   a. The timeframe to do a standard external review (45 days) would place the Your life, health or ability to regain maximum function in danger; or
   b. The decision is about admission, care availability, continued stay, or emergency health care services where the person has not been discharged from the facility.

To request an external review You must provide the following information:
- Name
- Address
- Phone
- Email address

- Whether the request is urgent
- Patient's signature if person filing the appeal is not the patient
- A brief description of the reason You disagree with Your plan's denial decision

Return this information to Us and within three business days We will provide this information to the appropriate independent review organization. Also, You may submit additional information for consideration of their external review request. For example, You may provide:

- Documents to support the claim, such as Physicians' letters, reports, bills, medical records, and explanation of benefits (EOB) forms;
- Letters sent to Your health insurance plan about the denied claim; and
- Letters received from the health insurance plan.

The independent review organization will provide its decision:

1. For a life-threatening condition, not later than the earlier of the third day after the date the organization receives the information necessary to make the determination; or
2. For a condition other than life-threatening condition not later than the earlier of:
   a. The 15th day after the date the organization receives the information necessary to make the determination; or
   b. The 20th day after the date the organization receives the request that the determination be made.